# JOINT MEETING
of
# COMMISSIONS ON MEDICAID CARE MANAGEMENT
and
# MEDICAL CARE ADVISORY COMMITTEE

WELL SENSE HEALTH PLAN

December 14, 2015

**Lisabritt Solsky**, Executive Director

# Our Mission

**Our mission is to serve** Boston Medical Center and to assist and support Boston Medical Center's mission in providing and enhancing access to effective, efficient medical care among low income, underserved, disabled, elderly and other vulnerable populations

WELL SENSE HEALTH PLAN

# Our Vision

**To be the managed care plan of choice for our stakeholders by:**

- Providing our Members with cost-effective access to a broad range of innovative, person-centered healthcare services to help improve their health and quality of life;
- Carefully stewarding the responsibilities entrusted to us by Government Agencies in pursuing the goal of improving the health of their populations;
- Working in close partnership with Healthcare Providers and Community Based Organizations to help them improve the efficiency and effectiveness of the care they provide.

# Our Local Presence


- Offices located in **Manchester** with over 50 employees from local communities
- In addition to being mission driven, we are the state's only not-for-profit Medicaid MCO
- Robust network of primary care, specialty and hospital providers in addition to behavioral health providers
- We presently serve over 86,000 Medicaid enrollees

# MEMBER SERVICES

WELL SENSE HEALTH PLAN

# Member Services

- **Manchester based Call Center staff** of 12 with back-up from Boston Call Center
- **Average 4,500 calls per month** from members and providers
- **98% of calls answered within 30 seconds**
- **Abandonment rate of only 0.2%**
- **Member Service Team expanded hours** 8-8 Mon-Wed and 8-6 Thurs-Fri

# Member Experience

## Concierge Level Service

- Members appreciate extended hours
- Access to all services through one telephone line
- Member extras: car seats, bike helmets, toothbrushes, and breast pumps for nursing moms
- Confirmation at close of call that we have addressed all of the member's questions

# Member Advisory Board

The **Member Advisory Board** (MAB) advises the Plan and makes non-binding recommendations to the Leadership of Well Sense Health Plan within the areas of their experience and expertise.

# Member Advisory Board

## The Member Advisory Board (MAB)

- MAB members are asked to review activities included in the quality improvement program which focuses on improving member's medical and behavioral health care, satisfaction and safety.
- MAB members are asked to review draft written materials and provide feedback on the relevance, readability and usefulness of materials.
- MAB members are also educated on the roles and responsibilities of departments within Well Sense to expand their knowledge and understanding of how Managed Care works.

# GRIEVANCE AND APPEALS

WELL SENSE HEALTH PLAN

# Volume, Outcomes, and Topics
# SFY 2015

## Volume

- **617** appeals
- **36** grievances
- **0** escalated to State Administrative Appeal

## Outcomes

- **277** abandoned
- **221** upheld
- **119** overturned

## Topics

- **All** were ‘denial or limited service’

WELL SENSE HEALTH PLAN

# PROVIDER ACTIVITIES

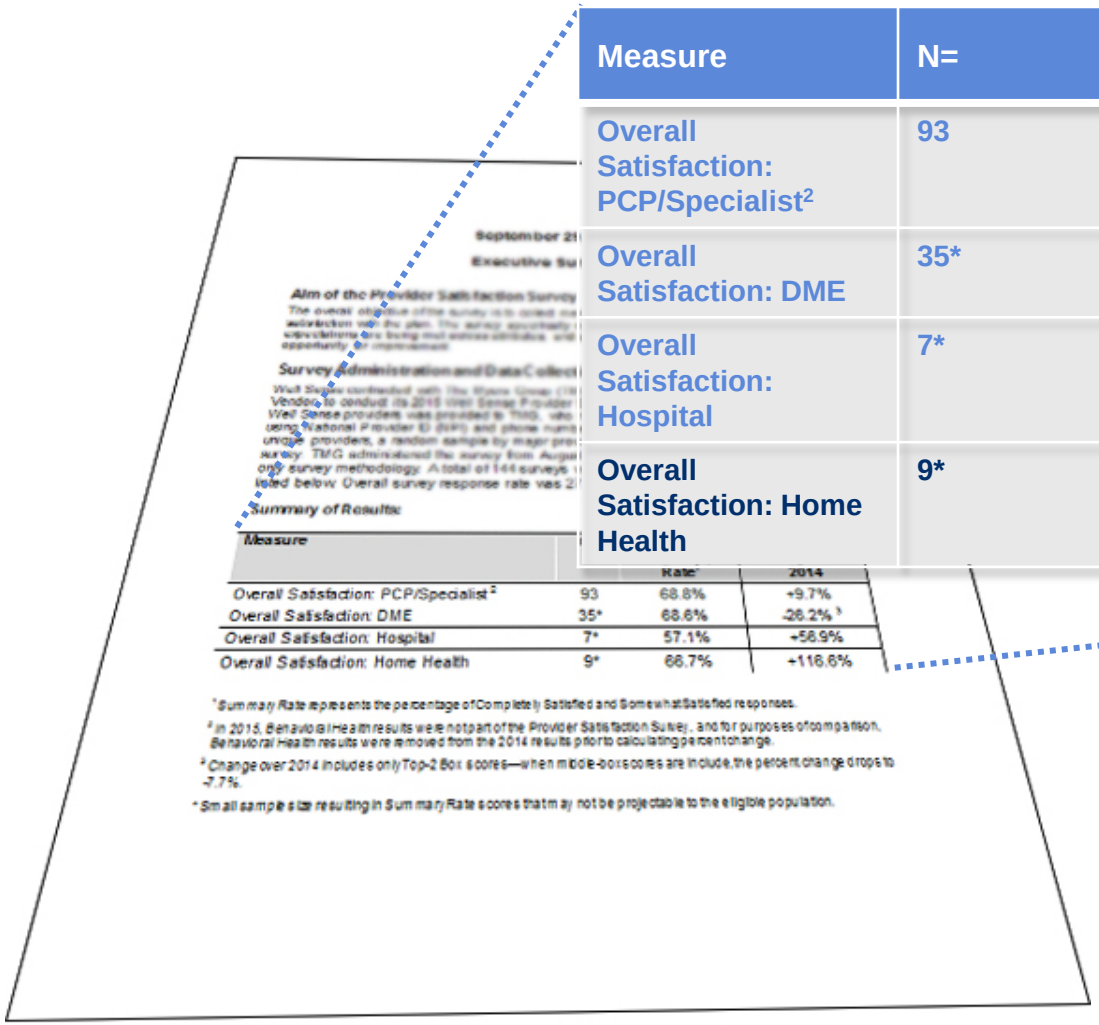
WELL SENSE HEALTH PLAN

# Well Sense Provider Advisory Council

- Consists of 10 Well Sense health care providers with geographical diversity and an administrator from GSIL as well as a CMHC
- Well Sense staff present includes medical director, executive director, quality manager, director network management, and behavioral health program director
- Meets 4 times per year
- Offers input to Well Sense regarding major policy decisions
- Provides staff with input regarding how the provider community perceives new rollouts, quality initiatives and ongoing operations
- Provides input regarding provider communication materials and education

# Provider Satisfaction Survey

| Measure | N= | Well Sense Summary Rate[1] | Percent Change over 2014 |
|---|---|---|---|
| Overall Satisfaction: PCP/Specialist[2] | 93 | 68.8% | +9.7% |
| Overall Satisfaction: DME | 35* | 68.6% | -26.2%[3] |
| Overall Satisfaction: Hospital | 7* | 57.1% | +56.9% |
| **Overall Satisfaction: Home Health** | **9*** | **66.7%** | **+116.6%** |



Summary of Results

| Measure | | Rate | 2014 |
|---|---|---|---|
| Overall Satisfaction: PCP/Specialist[2] | 93 | 68.8% | +9.7% |
| Overall Satisfaction: DME | 35* | 68.6% | -26.2%[3] |
| Overall Satisfaction: Hospital | 7* | 57.1% | +56.9% |
| Overall Satisfaction: Home Health | 9* | 66.7% | +116.6% |

[1] Summary Rate represents the percentage of Completely Satisfied and Somewhat Satisfied responses.

[2] In 2015, Behavioral Health results were not part of the Provider Satisfaction Survey, and for purposes of comparison, Behavioral Health results were removed from the 2014 results prior to calculating percent change.

[3] Change over 2014 includes only Top-2 Box scores—when middle-box scores are include, the percent change drops to -7.7%.

* Small sample size resulting in Summary Rate scores that may not be projectable to the eligible population.

WELL SENSE HEALTH PLAN

# CARE MANAGEMENT

WELL SENSE HEALTH PLAN

# Well Sense Care Management


## A Person Centered Care Integrated Team Approach

Integrated Care Management Model that encourages members to be aware of and participate in their own healthcare coordination and in maintaining optimal level of function in the appropriate setting.

Supports our members and providers to help coordinate care, improve health, and manage costs.

WELL SENSE HEALTH PLAN

# Care Management Programs

## Population-based Care Management

- **Population**: individuals with chronic conditions and at risk for other conditions/further decline in health (ex: diabetes, CAD, COPD, asthma, obesity, heart failure, hypertension)
- **Care Management**: lower touch, telephonic, focuses on helping members develop self-management skills; educational materials, arranging services for members with specific medical, behavioral, and social needs and interventions for specified diagnosis; individualized care plan, determination of available benefits and resources, including family supports and community resources
- **Goal**: self-management of chronic condition, connection to supports/services, prevention and promote wellness materials and education

# Care Management Programs (cont.)

## Complex Care Management

- **Population**: highest risk members with special needs, tri-morbid conditions, psycho-social issues, substance use disorders, acute traumatic events, high ED use, multiple specialists, frequent admits and/or re-admissions, may be homeless
- **Care Management**: most intensive level, high, frequent touch, multidisciplinary team, face-to-face visits, individualized care plan, coordination of multiple services through the healthcare continuum with ongoing monitoring and appropriate follow-up: provider, community, state, and Health Plan level; determination of available benefits and resources, including family supports and community resources
- **Goal**: stabilization, ensure nothing falls between the cracks, ED and admission avoidance, connected to PCP/medical home; receiving right care at the right place and right level; basic needs: housing, shelter, food, clothing, accomplishment of care plan goals

# Care Management Programs (cont.)

## Complex Care Management

Inpatient Transition to Home Care Management

- **Population**: Members who are inpatient with targeted diagnoses
- **Care Management**: telephonic management focusing on implementation of discharge plans, medication reconciliation, early identification of red flags, home safety, arranging transportation, facilitating appointments with PCPs and Specialists
- **Goal**: reduce inpatient re-admission; education, ensure follow-up care and refer into Complex CM or Population-based CM

# Care Management Programs (cont.)

## Complex Care Management

Sunny Start Maternal Child Health Program

- **Population**: Pregnant Members at-risk for an adverse delivery and/or who have postpartum needs; complex newborns
- **Care Management**: to promote a healthy pregnancy by identifying risks early, working with members to monitor these risks through delivery, and preparing members for what to expect and may need should they deliver a sick newborn. Screening is performed for all pregnancies for risk of adverse conditions impacting deliveries, with care management for high risk pregnancies focusing on education and support around signs and symptoms of preterm labor and pregnancy specific symptoms, hydration, nutrition, pre-natal care, smoking and substance use, pregnancy specific conditions. Complex newborns are managed by the same CM, establishing a Nurse in the Home.
- **Goal**: reduce prevalence of low birth weight births, reduce hospital days/NICU days, increase percentage of deliveries that had a postpartum visit, timeliness of pre-natal care

# Care Management Programs (cont.)

## Integrated Social Care Management

- **Population**: Vulnerable members with special needs, acute needs and long-term conditions with psychosocial care needs; Special Needs Population, Developmentally Disabled Population, Acquired Brain Disorders Population; and/or other LTCSS
- **Care Management**: multi-disciplinary, co-managed approach to support member's psychosocial care needs and anticipate, coordinate and join up health and social care; determination of available benefits and resources, including family supports and community resources; face-to-face visits, interventions occur at the member/family levels and system levels; dedicated resources to the waivered populations
- **Goal**: support members care in the least restrictive setting; ensure members have access to benefits at the Plan and State level and within the communities; appropriate long-term services and supports

# Care Management: Enhancements 2015

- FY15 additional care management staff added
- Created additional Complex Care Manager position in anticipation of needs of Step II mandatory enrollees
- 2nd Developmental Disabilities Care Manager for individuals on the DD, ABD and IHS waivers
- 2nd Long-Term Supports and Services Care Manager for individuals on the CFI waiver
- New Care Manager for Long-Term Care to support implementation of Step II services


WELL SENSE HEALTH PLAN

# Positive Member Outcome

## Member identified for Sunny Start program

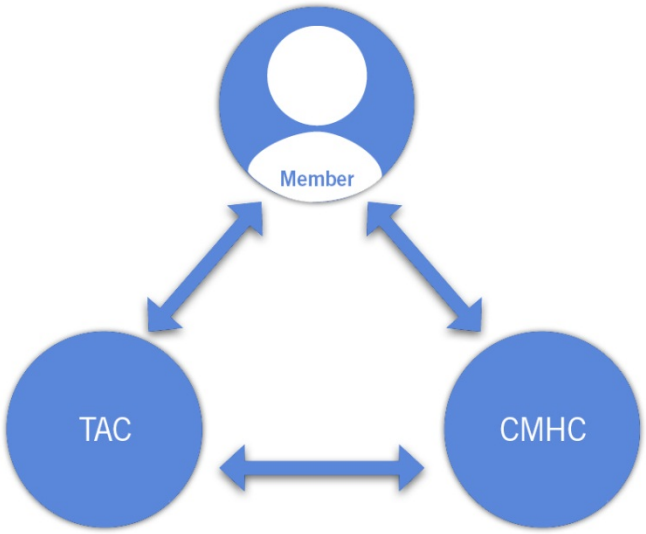
- **Problem:** weight loss in pregnancy
- **Barriers to care**: homeless, living in a tent; no transportation; no high school diploma; felt she couldn't take time off from work for fear of losing her job
- **Care Management Interventions**:
  - Nurse Care Manager offered Social Care Management, "I'm not keen on Social Workers" however did agree to a referral to Social Care Management
  - Co-managed by Well Sense Sunny Start Care Manager and Social Care Manager
  - Connected member with Child and Family Services Outreach Program and Healthy Families Program
  - Collaborated with nurse at Goodwin Community Health to support member in weight gain through pregnancy
  - Conducted in-person meetings with member, fiancé, and Healthy Families Program in member's town
  - Provided support in finding a room to rent with fiancé and then renting a single bedroom apartment from same landlord
  - Provided Member with a Well Sense car seat and breast pump
  - Collaborated with charities to provide bassinet, toys, baby clothing; items delivered directly to member
  - Identified online learning courses for member to complete high school degree
- **Outcome:** member delivered a healthy baby

# BEHAVIORAL HEALTH

WELL SENSE HEALTH PLAN

# Well Sense Behavioral Health and Beacon Health Options

## Transforming the lives of our members




### Member Focused Care

- Creative strategies to engage our members and families in treatment

### Goal

- Enable longer term community tenure by providing robust care management


- High Touch
- Care Coordination
- NHH liaison
- Well Sense Care Managers
- Medical Providers
- Agency/School Providers
- SUD services

TAC

Behavioral health expertise through

Education
Coordination
Communication

CMHC

Outpatient care
Medication Management
SUD
ACT services

WELL SENSE HEALTH PLAN

# Results

- **Partnership developed between the CMHCs and Beacon TACs**
- **Reduced re-admission rates**
  (30 day readmission rate, 2014=13.27%; 2015 = 7.95%)
- **Reduced length of stay at Inpatient Mental health hospitals**
  (2014 ALOS = 9.05; 2015 ALOS = 7.9)
- **Increased network of SUD services,** included SCA providers in bordering states

# Well Sense/Beacon Model for SUD Services


- Member contacts Beacon for support and referrals to programs and services
- Inquiry for services and support to address current SUD issues

- Assessment of immediate needs
- Information provided for immediate supports
- Exploration of potential referrals and resources

- Provide support needed to address current issues and risks
- Refer to various treatment options and resources as appropriate

- Interventions and treatment provided to meet member needs
- Assess appropriate Level of Care (LOC) to address current needs
- Appropriate LOC treatment and referral

- Refer for ongoing treatment and support services
- Beacon and Program to assess options for continuum of care
- Continue to provide referrals and support to address SUD issues

**Engage members, programs, and Beacon for comprehensive care.**

WELL SENSE HEALTH PLAN

# QUALITY IMPROVEMENT DEPARTMENT

WELL SENSE HEALTH PLAN

# Quality Activities

## Quality Assessment and Performance Improvement Plan (QAPI)

- The QAPI Work Plan is based on the Quality Improvement (QI) Program Annual Work Plan.
- Outlines projects the Plan has actively worked on to improve quality of care and services to members and promote safe clinical practices.
- The Plan provides detailed information on the ongoing quality activities, goals, data, identified barriers and specific actions taken for each project during the current year.

# Quality Activities

**Projects designated as QI Projects meet the following criteria:**

- Contain performance goals that are measurable
- Utilize baseline measurements, benchmarks and/or appropriate goals that are attainable
- Identify owners, project teams and project plans with realistic and significant interventions
- Goals are tracked and trended over time

**QI Project goal ongoing evaluation and oversight:**

- Year-end data results are used to adjust and establish performance, monitor progress and establish new goals for the coming year
- A final analysis for each project is provided to DHHS annually

# Quality Activities

## Quality Improvement (QI) Program Annual Work Plan

**Key areas of focus**:

- Support the company's mission and strategic goals
- Are identified through the monitoring of quality metrics, the evaluation of the previous QI work plans and from input received from practitioners and/or members
- Improve the overall health, well-being and safety of Well Sense members
- Improve member and provider satisfaction
- Improve member access to appropriate health care
- Supports patient safety
- Address the cultural and linguistic needs of members
- Fulfill National Committee for Quality Assurance (NCQA) accreditation goals and regulatory requirements

# Quality Activities

**QI Work Plan Projects:** Many projects are based on DHHS quality strategy which includes performance improvement projects (PIP) and others are Healthcare Effectiveness Data and Information Set (HEDIS) & Consumer Assessment of Healthcare Providers and Systems (CAHPS) based projects.

## Work Plan Projects:

- Asthma Disease and Care Management Program
- Diabetes Disease and Care Management Program
- Prenatal and Postpartum Care Program
- Follow-up after mental health hospitalization
- Cultural and Linguistic Needs Disparities Initiative
- Member satisfaction (CAHPS)
- Special needs Care Management Program
- Prescription Drug Monitoring Program: Patient Safety Project

## Performance Improvement Projects:

- Diabetes Care: screening for Nephropathy
- Percent of women ages 16-24 receiving chlamydia screening
- Well Child Visits in children ages 3-6
- Reducing readmissions to NH Hospital

# Quality Activities

## QI Work Plan Accomplishments:

- Implemented many activities and established processes to identify and educate members regarding appropriate preventive care and self-management of chronic conditions
- Through the Provider Quality Incentive Program (QIP) and overall quality activities, the Plan has engaged many providers and provider groups throughout the state to promote and collaborate on quality improvement activities and educate providers on best practices
- Engaged with state-wide collaborates to help align quality improvement activities
- Implemented a Wellness and Disease Management workgroup to develop and implement member and provider focused interventions
- Monitor the Well Sense membership for the prevalence of conditions and trend data
- The Plan's NCQA accreditation ranking increased from Accredited to Commendable

# Community Outreach

Well Sense Health Plan's unique approach to relationship building within the communities that we serve

# Community Outreach

- Team travels throughout the state to educate members, potential members and organizations about Well Sense
- Collaborates with local community-based organizations and providers to provide support for special events and activities
- Works internally to coordinate volunteer opportunities that allow Well Sense staff to engage in the community

# Community Outreach

- Attended 106 events throughout NH during FY15
- Coordinated volunteer opportunities with the following organizations:
  - Families in Transition
  - United Way of the Greater Seacoast
  - Granite United Way
  - NH Food Bank
  - Special Olympics of NH

# Community Outreach

**Provided Well Sense members with the following extras:**

- **Car seats:** 8,361
- **Bike helmets:** 2,633
- **Dental kits:** 7,452
- **Manual breast pumps:** 988
- **Cases of diapers**: 254

# Community Outreach

July 9, 2015

Dear Caitlin,

All of us at the New Hampshire Food Bank would like to thank Well Sense for taking the time to prepare and distribute this Mobile Food Pantry. Thanks to your support, 400 bags of nonperishable goods reached over 200 families that struggle to put food on the table. Your hard work provided approximately 5,830 meals for the hungry of New Hampshire, and the hours generously spent at our organization are valued at a total of $505.00!

As the only food bank in the state, the New Hampshire Food Bank is a vital distributor and supplier to the hunger relief agencies that serve meals and provide groceries to people facing food insecurity. Volunteers are a central component of the NH Food Bank's efforts to help the 1 in 9 New Hampshire residents struggling to make ends meet - including children, senior citizens and entire families. This could not happen without the generous gift of time and talent from volunteers like you!

Again, thank you so much for supporting our mission and helping the NH Food Bank feed the hungry of New Hampshire.

Sincerely,

D'Loughy
nteer Coordinator
69-9725 x 131
ghy@nhfoodbank.org

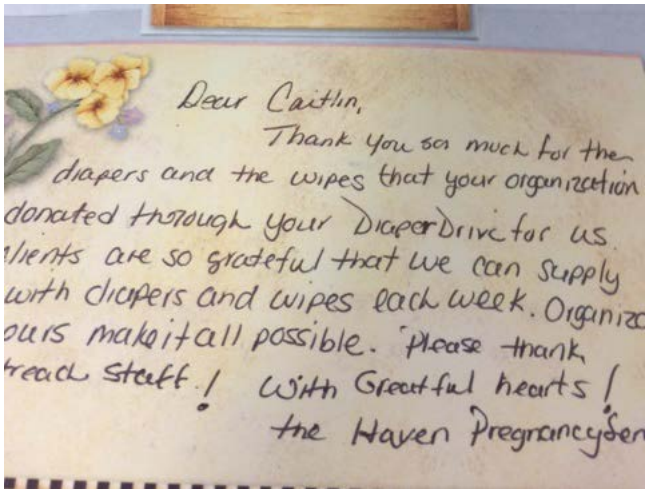
HOLIC
RITIES

700 EAST INDUSTRIAL PARK DRIVE MANCHESTER, NH 03109 603.669.9725 FAX 603.669.0270 NHFOODBANK.ORG

FEEDING AMERICA


WELL SENSE HEALTH PLAN

# Community Outreach






WELL SENSE HEALTH PLAN

# FRAUD, WASTE AND ABUSE (FWA) PREVENTION, DETECTION AND INVESTIGATION

WELL SENSE HEALTH PLAN

# Well Sense FWA Team

## Well Sense Special Investigations Unit (SIU):

- Combined 27 years of experience
- SIU Manager
- Two SIU investigators
- An SIU Coordinator
- A data analyst

# Well Sense FWA Activities: FY15

- 1800 Member Services Verification Letters
- FWA training
- Quarterly vendor FWA meetings
- Internal and third party vendor post-payment data mining/ FWA database
- FWA Investigations-triaged:
  - 412 possible ineligible members (70 referred)
  - 46 suspected FWA referrals (25 cases opened)
  - Matching transportation and medical claims to identify possible fraud

# QUESTIONS

**Thank you.**

**Lisabritt.Solsky@wellsense.org**
**603-263-3036**

WELL SENSE HEALTH PLAN